



HEALTH IMPROVEMENT
PARTNERSHIP OF
MARICOPA COUNTY



COMMUNITY HEALTH IMPROVEMENT PLAN

MARICOPA COUNTY

2018 - 2023



Maricopa County
Department of Public Health

Preface

This report describes the Community Health Improvement Plan (CHIP) of Maricopa County, a community-initiated plan to address the three public health priorities determined by the recent Maricopa Coordinated Community Health Needs Assessment (CCHNA) in 2017. These public health priorities are: improving Access to Care, Access to Healthy Foods and quality Early Childhood Development experiences. The purpose of the CHIP is to set priorities, coordinate and target resources, and define actions taken by members of the public health system to promote health. The CHIP identifies strategies that can improve the quality of life for all Maricopa County residents, particularly the most vulnerable in our community, by reducing preventable illness and promoting wellness.

The CHIP is the action plan result of a three-year long community health needs assessment. The 2017 Coordinated Community Health Needs Assessment for Maricopa County was conducted with an orientation to “upstream” determinants related to social, economic, and environmental factors. Differences in income, employment, education, housing, transportation, crime, and host of other social determinants follow geographic and demographic patterns that create steep gradients between neighborhoods and groups of people. The corresponding health inequities that arise among these places and people follow the same patterns and suggest the presence of systemic “root causes” that may drive downstream impacts on community and individual health. The 2017 CCHNA focused on identifying these root causes so health improvement planning can be designed to address them. The result was the prioritization of three “root causes” of many public health conditions.

The Health Improvement Partnership of Maricopa County (HIPMC) is a collaborative effort between Maricopa County Department of Public Health and more than 100 public and private organizations addressing the priority health issues originally established in 2012 to design and implement the original Community Health Improvement Plan. Many participants are from organizations that have been involved since the CHA process, while others continue to join as the CHIP takes shape.

The information provided in this report is intended for the use of members of Maricopa County’s public health system and to inform the community health improvement process among the broader Maricopa County community. The CHIP Action Plan is updated annually and revised every five years based on the most recent community health needs assessment.

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The **Health Improvement Partnership of Maricopa County** is a collaborative effort between the Maricopa County Department of Public Health and the more than 100 public and private organizations listed below.

Abrazo Health, Maryvale Campus	Keep Phoenix Beautiful
Abrazo Health, West Campus	Kyrene School District
Adelante Healthcare	Lifewell Behavioral Wellness
Aetna	Magellan Health Services
Alliance for a Healthier Generation	Maricopa Integrated Health System
Alzheimer's Research and Prevention Foundation	Maricopa Association of Governments
American Cancer Society	Maricopa County Air Quality
American Heart Association, Arizona Chapter	Maricopa County Community College District
American Lung Association, Arizona Chapter	Maricopa County Correctional Health Services
Anthony Bates Foundation	Maricopa County Department of Public Health
Arizona Action for Healthy Kids	Maricopa County Education Service Agency
Arizona Alliance for Community Health Centers	Maricopa County Food Systems Coalition
Arizona Alliance for Livable Communities	Maricopa County Office of the Legal Defender
Arizona Coalition for Military Families	Maricopa County Wellness Works
Arizona Community Action Association	Maricopa Medical Society Alliance
Arizona Department of Education	Mayo Clinic
Arizona Department of Health Services	Medical Accessibility, LLC
Arizona Family Health Partnership	Mercy Care Plan
Arizona Health and Physical Education	Mercy Maricopa
Arizona Hospital and Healthcare Association	Midwestern University
Arizona in ACTION	Mission of Mercy Mobile Medical Clinic
Arizona Living Well Institute	National Kidney Foundation of Arizona
Arizona Public Health Association	Native American Connections
Arizona Public Interest Research Group (PIRG)	Native Health
Arizona Small Business Association	Phoenix Children's Hospital
Arizona Smokers' Helpline	Phoenix Fire Department
Arizona Spinal Cord Injury Association	Phoenix Revitalization Corporation
Arizona State University, College of Health Solutions	Pinnacle Prevention
ASU Southwest Interdisciplinary Research Center	Preventive Health Consulting, LLC
Artisan Food Guild	Protecting Arizona's Family Coalition (PAFCO)
Asian Pacific Community in Action	RightCare Foundation
Az. Chapter of the American Academy of Pediatrics	Roosevelt School District
Banner Health	Southwest Autism Research and Resource Center
Be A Leader Foundation	Southwest Center for HIV/AIDS
Blue Cross Blue Shield of Arizona	St. Vincent de Paul Family Wellness Program
Boys & Girls Clubs of Metro Phoenix	Susan G. Komen Arizona
Brain Body Fitness	Tanner Community Development Corp.
Bridgeway Health Solutions	Terros/LGBTQ Consortium
Chicanos por la Causa	The Arizona Partnership for Immunization
Cigna	The Faithful City
City of Goodyear	The Wellness Community - Arizona
City of Phoenix- FitPHX	Touchstone Behavioral Health
City of Phoenix Housing Department Hope VI	Town of Gila Bend
Crisis Preparation and Recovery	Trans Queer Pueblo
Dignity Health Chandler Regional Medical Center	Unified in Hope
Dignity Health Mercy Gilbert Medical Center	United Healthcare
Dignity Health St. Joseph's Hospital and Medical Center	University of Arizona Cooperative Extension
EMPACT	University of Arizona College of Medicine
Esperanza	University of Arizona – Mel and Enid Zuckerman College of Public Health
Family Involvement Center	Unlimited Potential
Feeding Matters	Valle del Sol
First Things First	Valley Metro
George B. Brooks Sr. Community School	Valley of the Sun United Way
Greater Valley Area Health Education Center	Valley Permaculture Alliance
Health-eOptions	Virginia G. Piper Charitable Trust
Healthways, Inc.	Viridian Health Management
Healthcare Information and Management Systems Society	Vitalyst Health Foundation
Healthy Arizona Worksites Program	Walgreens
Helping Families in Need	Wesley Community and Health Center
HonorHealth	
International Rescue Committee	

Acknowledgements

A work of this magnitude can be accomplished only through a collaborative effort involving groups and individuals too numerous to name. Here we recognize many of our effort's key leaders, supporters, and contributors, but we also wish to thank the many others whose participation and assistance enriched the process and made this CHIP possible.

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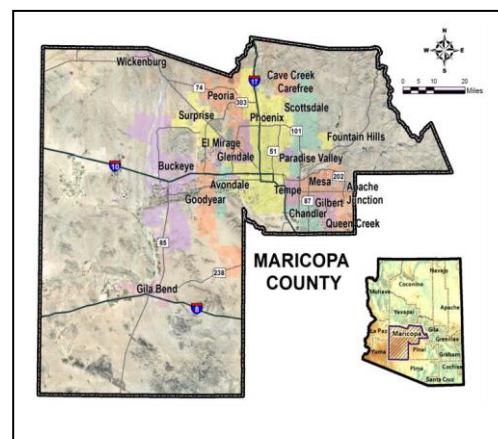
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Maricopa County Community Profile

Maricopa County, Arizona, is the fastest growing county in the United States, adding more than 222 persons per day in 2016, with more than 4.2 million residents at present. Maricopa County encompasses over 9,200 square miles, roughly the size of the state of Massachusetts, composed of a mix of urban, suburban, and rural areas including the whole or parts of five sovereign American Indian Reservations. Home to nine out of ten of the state's largest cities including Phoenix (the fifth largest city in the U.S.), Maricopa County serves as the state's primary metropolitan, political, and economic center. The county is the third largest public health jurisdiction in the country and is served by the Maricopa County Department of Public Health.



Population Demographics. Maricopa County is the fastest growing county in the United States, adding more than 222 persons per day in 2016. Maricopa County's population growth was almost double that of Arizona and the U.S. Net domestic migration accounted for most of the Maricopa County's growth, with the addition of 43,189 people. The county also added 25,428 people from natural increase and 10,188 people from net international migration. The largest increases in population were seen in the 65 to 74 year old age group (22%) and among African Americans (13.2%) and American Indians (13.2%). Gender distribution is approximately equal across Maricopa County, the state, and the nation. The age distribution for Maricopa County (and Arizona) is slightly younger than that of the U.S. as a whole. Maricopa County (and Arizona) has a notably larger proportion of Hispanics than the nation, at almost double the percentage. Maricopa County (and Arizona) also has a greater percentage of American Indians. In contrast, Maricopa County's proportion of African Americans is substantially lower.

Educational Attainment. Educational attainment in Maricopa County is roughly equivalent to that at the state and national levels. More than 90% of Asians are high school graduates or higher, while these percentages are in 70s for Pacific Islanders (79%), African Americans (76%), and Hispanics or Latinos (74%). The percentage is lowest among Native Americans at 64%.

Employment Status. Maricopa County's unemployment rate of 5.6% in 2015 was higher than the national average of 5.3% in the same year. Among races/ethnicities, American Indians had the highest unemployment rate in the county (11.5%). Asians had the lowest (4.7%) followed by Whites (5.0%). Younger residents of Maricopa County had the highest levels of unemployment, while the 35-44-year-old age group had the lowest (3.8%).

Income/Poverty. Maricopa County's poverty rate (17.1%) is higher than the nation's (15.6%), but not as high as Arizona's (18.2%). The median household income in Maricopa County is lower than that for the state and nation and is lowest among Blacks/African Americans. The CCHNA community survey asked, "On a monthly basis, do you have enough money to pay for essentials such as food, clothing, and housing?" Overall, 5.2% of respondents indicated that they never have enough money for these essentials, while 43.4% said they sometimes have enough money, and 54.4% said they always have enough. (See MCCHNA Reports for a more extensive community profile at MaricopaHealthMatters.org.)

Maricopa County Coordinated Community Health Needs Assessment

The purpose of community health assessment is to gather up-to-date information to paint an accurate portrait of the community's health status upon which planning for future community health improvement activities can be based. Community health assessment is the first stage of a multi-year process to identify and prioritize strategic health issues, develop and implement strategies to address those issues, and establish accountability for measurable community health improvement. The 2017 Coordinated Community Health Needs Assessment (CCHNA) completed an 18-month long process through the prioritizing the strategic community health issues. The 2017 CCHNA reports can be found on MaricopaHealthMatters.org.

The 2017 CCHNA was conducted in partnership with the HIPMC and Synapse, a collaborative of four non-profit hospital systems representing 22 hospitals in Maricopa County and two federally qualified community health centers representing 14 clinics in the county. This collaborative has joined resources for a comprehensive community health assessment. Deviating from prior assessments that focused on prevailing health conditions, this CCHNA integrated an "upstream" determinants approach that included social, economic, and environmental factors influencing health. This population health approach aims to show that differences in income, employment, education, housing, transportation, crime, and other social determinants follow geographic and demographic patterns that create steep gradients between neighborhoods and groups of people.

The corresponding health inequities that arise among these groups of people follow the same patterns and suggest the presence of systemic "root causes" that may drive downstream impacts on community and individual health. After much analysis and consideration, the three priority strategic issues that emerged from the recent assessment are improving Access to Care, Access to Healthy Food, and Early Childhood Development. These are broad determinants that contribute to several downstream issues and health outcomes. This Community Health Improvement Plan (CHIP) completes the health assessment process by delineating the development and implementation of strategies to address those issues and establish accountability measures for community health improvement.

Three Public Health Priorities for the Maricopa County Community Health Improvement Plan

Priority Areas and Goal

1. **Access to Care:** To increase access to quality, comprehensive health and wrap around services.
2. **Access to Healthy Food:** To increase access to health food.
3. **Early Childhood Development:** To improve early childhood experiences.

The Maricopa County Community Health Improvement Plan

Community Health Improvement Planning

Once the three strategic priorities were identified through the CHA process, stakeholders turned their attention to making key decisions to construct the 2018-2023 Community Health Improvement Plan (CHIP). These decisions guided by the MAPP framework and PHAB Standards included identifying:

- Priorities for Action
- Desired Outcomes
- Measurable Objectives
- Policy and System Changes Needed
- Improvement Strategies
- Workgroup Structure and Action Plan Implementation
- Process for ongoing review & revision

Community Priorities for Action

To delve deeper into these three strategic priorities, a series of workgroup meetings were implemented between August 2017 and January 2018. These meetings convened by the MCDPH CHIP project team engaged both HIPMC partners and MCDPH subject matter experts to accomplish several goals.

At the HIPMC Quarterly meeting held in July 2017, HIPMC partners were briefed on the workgroup process and invited to self-select which of the three priority area workgroups for which they wanted to participate. Partners were also encouraged to identify other community stakeholders who may be interested in participating and extend them an invitation to become a "CHIP Strategist" using a clever Mad Libs-style invite. CHIP strategists gathered in their respective priority area workgroups between August and October to work through the following process led by the following questions:

1. **Who's Not Thriving?**
Select a specific population focus that addresses who's not thriving
2. **What is Currently Happening?**
Develop a picture of the organizations, people, relationships, and resources which exist in the focus area
3. **What Do We Want to See Improve in the Next 3 Years?**
Define a specific and measurable 3-year aim
4. **What Primary Drivers Need to Move in Order to Reach Our Goal?**
Visualize a theory of change on a driver diagram
5. **What is the Action Plan for 2018?**
Create an action plan and measurement system that allows for continual improvement and real-time results-based decision making.

This framework stems from the *Core Concepts and Principles of the Community of Solutions* from *SCALE Community of Solutions Model* of which HIPMC is a member. The *Core Concepts and Principles* delineate practices by leaders and participatory community engagement to approach change in order address long term inequity and support abundance. (See Appendix A for more on the Core Concepts.)

Workgroup members sifted through CHA data in each of the three priority health areas at the county level and disaggregated data from underserved geographic locations and by race/ethnicity, age, sex, and socioeconomic status. A “data gallery” was constructed as a user-friendly method to display and share the data as well as generate meaning about the information. The focus questions resulted in requesting additional data for specific communities and reviewing opportunities and gaps. Workgroup members also developed system maps using the *Spectrum of Community Engagement* framework from Vitalyst Health Foundation, a HIPMC Champion Partner. The results of these activities provided context of existing work in targeted, underserved communities.



Although the original intent was to complete setting goals and objectives within these workgroups, it became clear that the original process conceived was not effective and consensus of the stakeholders could not be reached in the time allotted. Additionally, as often happens with workgroups of volunteers, participation fluctuated at each meeting. After a strategy pivot, developing the driver diagrams for the three priority areas refocused the CHIP process on upstream, root causes and provided the partnership with strategic direction. Consultative meetings with MCDPH subject matter experts, some of whom had been involved in the previous workgroup meetings and some who were recruited to join at this stage, provided context of the CHA data and expertise on research-based root cause analyses. This information was presented to workgroups of stakeholders who created three strategy maps. The output was visualized as driver diagrams and presented to the HIPMC partnership for review in January 2018.

Driver Diagrams of the Community Priorities for Action

The January 2018 HIPMC meeting was an ending and a beginning. Partners came together to celebrate the progress made during the 2012-2017 CHIP cycle and to review the draft driver diagrams for the 2018-2023 CHIP priority areas. Meeting participants reviewed these diagrams and provided feedback as well as participated in a facilitated activity to identify the secondary driver strategies their organizations were already working. HIPMC partners who were not able to attend the January meeting were invited to provide the same guidance on the driver diagrams through an electronic survey.

The HIPMC Steering Committee met in March 2018 to review the revised driver diagrams and the HIPMC partner input. To continue action planning, an approach was presented whereby the CHIP action plan would concentrate on a *Focused Driver* and a workgroup would be formed to complete the goal and objectives pieces of the plan. Evaluation of this would include collecting data, monitoring, and reporting progress. The remaining *Drivers* would not warrant workgroups but would be included in the overall framework for action and partners would continue their work in those areas.

A *focused driver* was then selected as the priority for action for each of the three strategic health priority areas based on the HIPMC partners' input. For Access to Care, **cost of care** was selected as the priority for action, including provider incentives to address root causes and social determinants, utilization of preventive services and use of community health programs by clinical care providers. The full driver diagram for this priority is below.

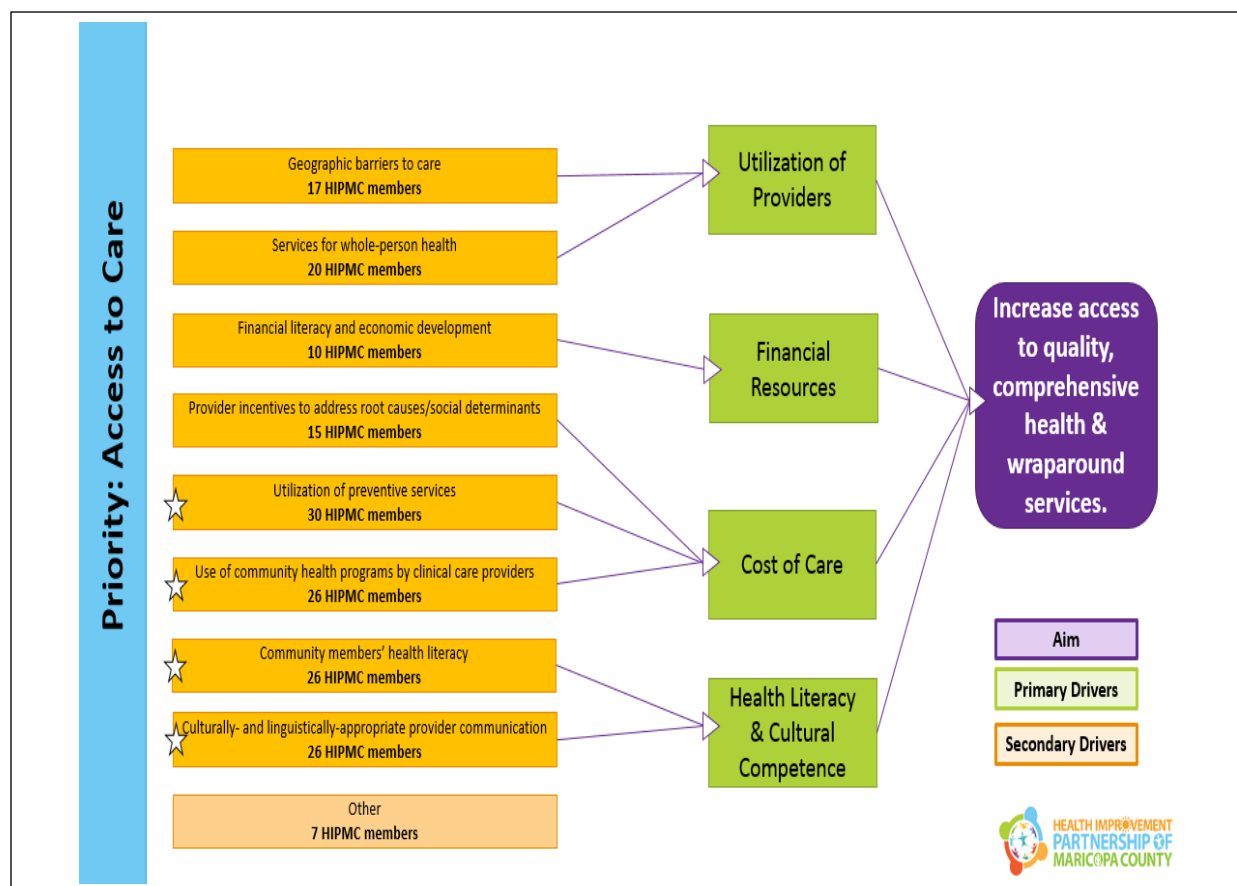


Figure 2 Access to Care Driver Diagram

For Access to Healthy Food, **availability** was identified as the priority for action and included considerations such as regulations regarding sales from locally-grown or produced foods, local food production, convenience of healthy foods and availability of healthy and culturally appropriate foods. The full driver diagram for this priority is below.

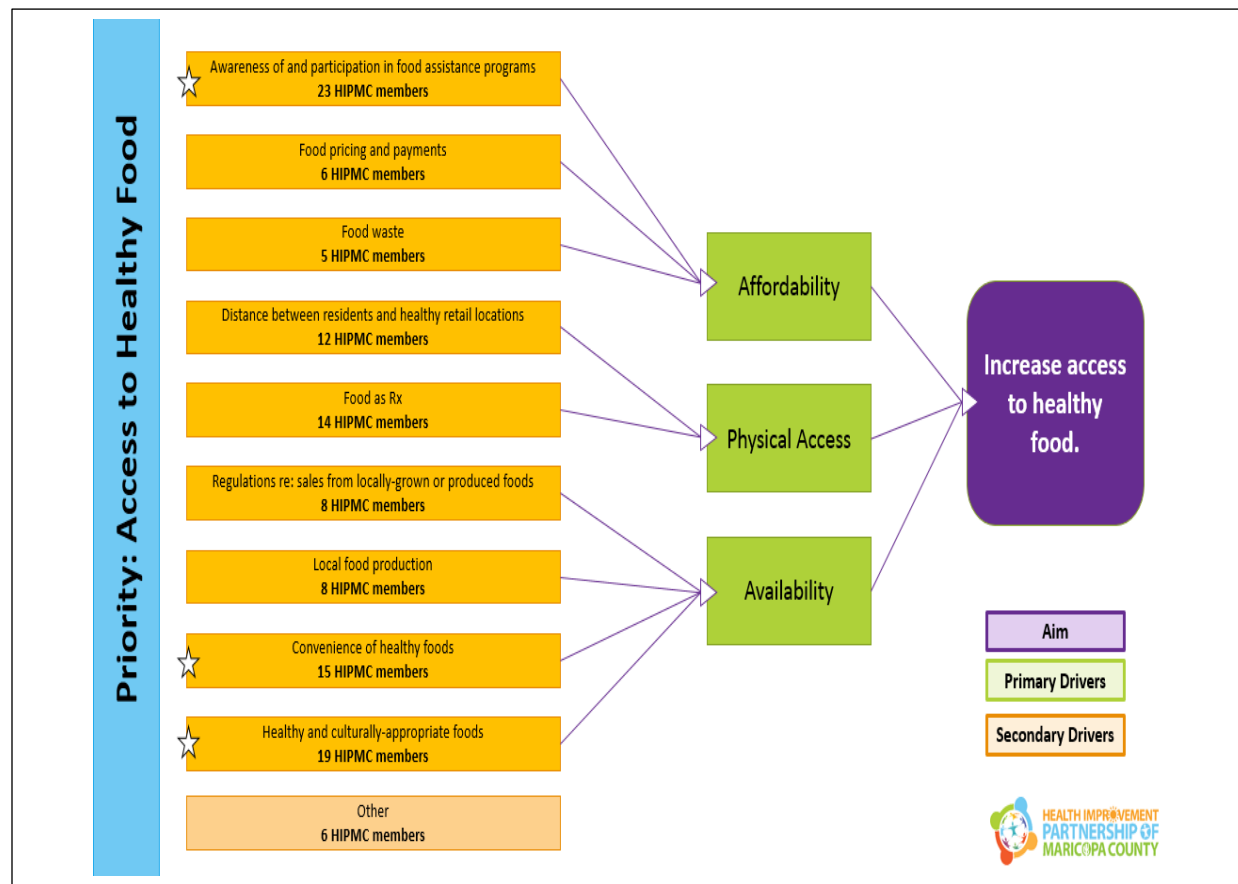


Figure 3 Access to Healthy Food Driver Diagram

The priority for action identified from the Early Childhood Development driver diagram was **access to preventive care** which included consideration of comprehensive health services offered in non-traditional settings, preventive screenings happening in and out of healthcare settings and free or affordable wrap around services for families. The full driver diagram for this priority is below.

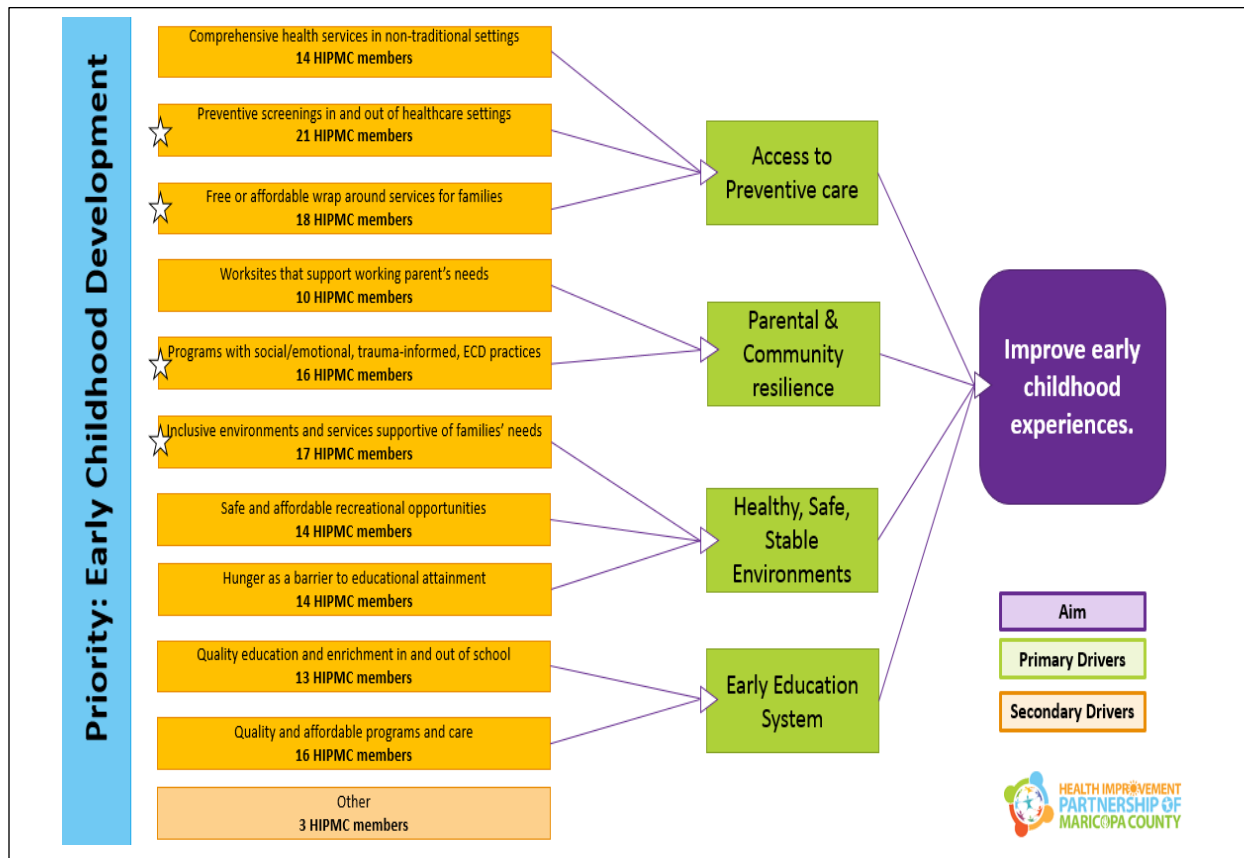


Figure 4 Early Childhood Education Driver Diagram

Desired Measurable Outcomes or Indicators of Health Improvement; Priorities for Action

Once the priorities for action for each of the three strategic priorities were approved, the HIPMC Steering Committee shifted its attention to identifying subject matter experts who could develop recommendations for goals and identify desired outcomes that were feasible given the current community context. At the April 2018 HIPMC partner meeting, participants were briefed on the above selected priorities for action and brainstormed additional stakeholders who should be involved in the CHIP design process. These recommendations were then reviewed by the Steering Committee and approximately 20 subject matter expert stakeholders were invited to participate in a two-part goal-setting process convened by the MCDPH CHIP project team in June of 2018. These SME stakeholders included representatives from underserved communities, staff of community-based organizations from the private sector, funders, MCDPH staff, and non-traditional public health partners that were not HIPMC members. The following table delineates the cross-sector organizations of those invited to participate.

Access to Care	Access to Healthy Food	Early Childhood Development
Association of Community Health Centers Native Health (FQHC) Valle del Sol (FQHC) Adelante Healthcare (FQHC) Mountain Park Health Center (FQHC) Arizona Hospital & Healthcare Association Terros, Behavioral Health First-Responders (EMS) Crisis Response Network Frameshift Group Maricopa Integrated Healthcare System Equality Health Vitalyst Health Foundation Mayo Clinic MCDPH	Maricopa County Food System Coalition MCDPH Cardno/ATC Group Services Crooked Sky Farms Local Farmers International Rescue Committee City of Phoenix – Office of Environmental Programs United Way Desert Mission Food Bank Association of Arizona Food Banks Shamrock Foods Live Wellthy, LLC Vitalyst Health Foundation MC Environmental Health Services	First Things First American Academy of Pediatrics - AZ Chapter Family Involvement Center Southwest Human Development Children’s Developmental Center AZ Headstart Association, Chair of Early Childhood Development Committee Maricopa County Public Health Arizona Partnership for Immunization (TAPI) Arizona Early Intervention Program Arizona Department of Health Services Grand Canyon University Health Services Advisory Committee (MCHS) Eyes on Learning

Figure 5 Member Organizations Participating

These subject matter experts met individually by health priority to review the data, discuss observations and insights not reflected in the data, and drafted recommendations for 3-5-year goals. All the groups decided to draft five-year goals due to the complexity of the issues. Key tools used during these meetings included *Touchstones for Collaboration* from the *100 Million Healthier Lives Initiative* and a four-point logic model diagram.

In discussing the present context for the goal setting, the groups returned to the results of the discussion on communities that are not thriving, the data related to those communities, and their related community assets. The

access to healthy food group focused on the community of South Phoenix due to the health disparities, low income, but strong community advocacy for action and healthy eating. The other two SME workgroups discovered their desired system changes aligned. The combined group focused on cost of care considerations and the one discussing access to preventive care and its implications on early childhood development worked together to refine a single 5-year goal recommendation rather than creating two separate ones. The initial focus of this work is with the veteran population in the County. These two goals are described below.

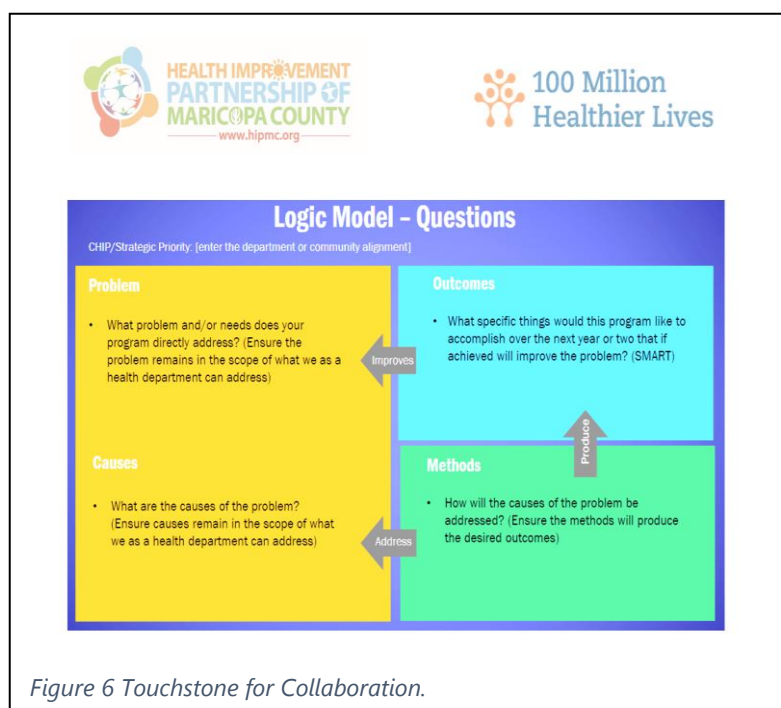


Figure 6 Touchstone for Collaboration.

2018-2023 CHIP Outcome Goals



Access to Care & Early Childhood Development

IDEAL: Clinical providers serving people in the highest-need areas of Maricopa County will have a way to connect patients to wrap-around services.

WHEN: By 2023

WHO: HIPMC

WHAT: 15% of medical providers (50% of which are pediatricians) utilizing a centralized closed-loop referral platform addressing all 12 Elements of a Healthy Community

WHERE: Zones reflecting the lowest life expectancy in Maricopa County

Figure 7 CHIP Outcome Goals Access to Care & Early Childhood Development

2018-2023 CHIP Outcome Goals



Access to Healthy Food

IDEAL: Individuals with historically low food access will more easily find locally-grown & nutritionally-dense produce.

WHEN: By 2023

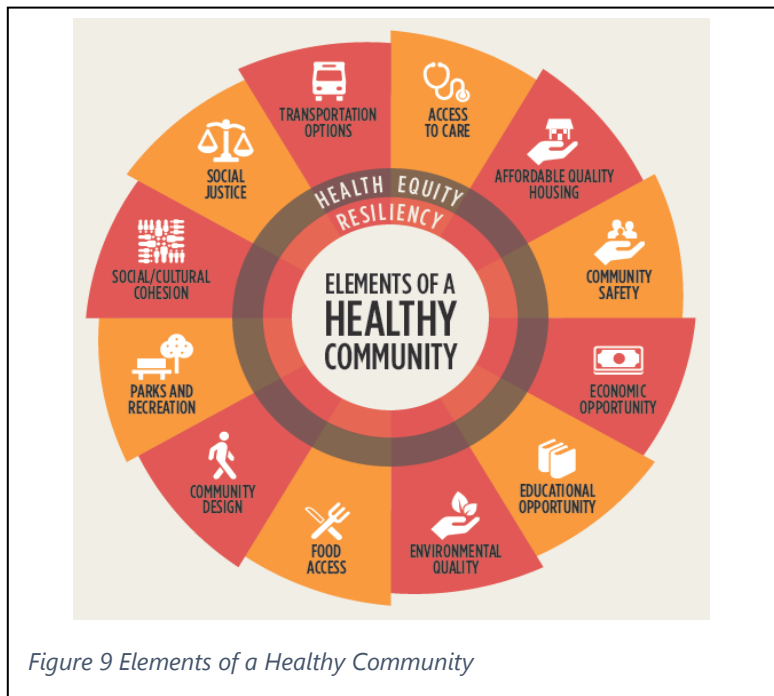
WHO: HIPMC

WHAT: Add 100 food outlets that offer locally-grown produce to residents

WHERE: Low-income/low-access areas in Maricopa County.

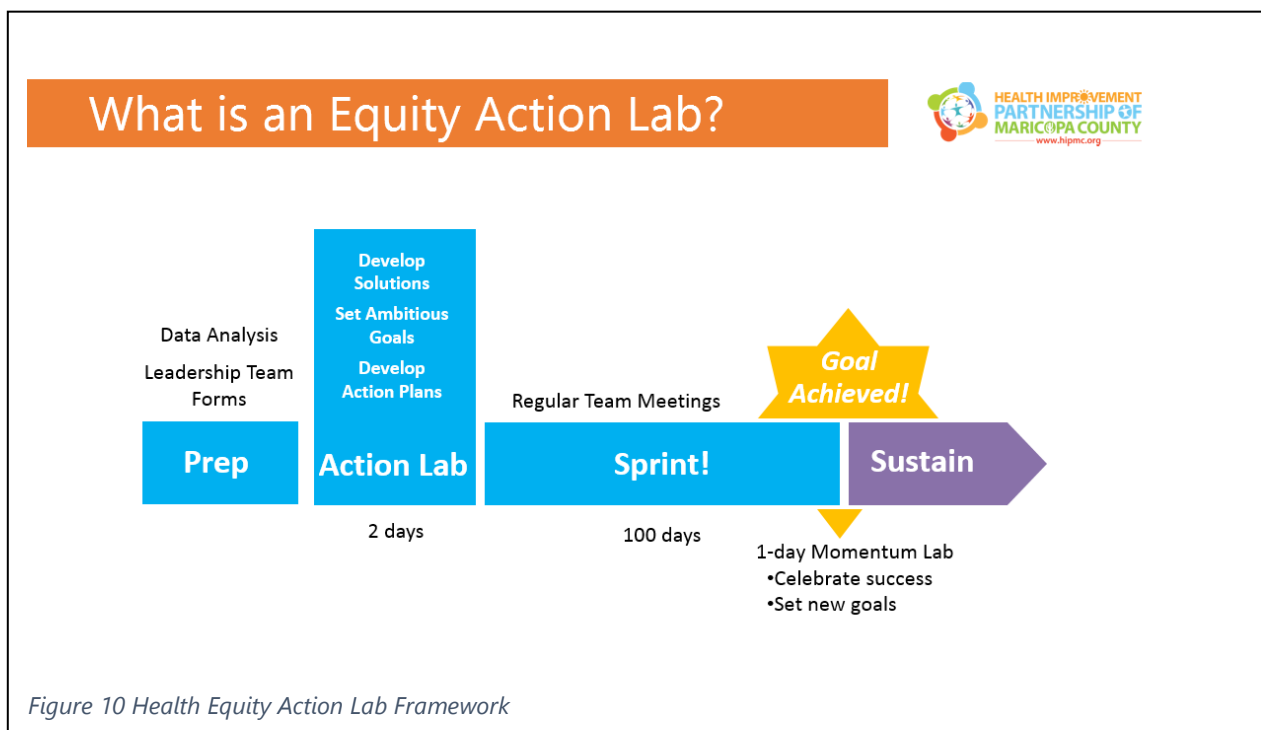
Figure 8 CHIP Outcome Goals Access to Healthy Food

The *Elements of a Health Community* was designed and produced by Vitalyst Health Foundation, a HIPMC Champion Partner, in collaboration with community partners. The elements are inspired by the work of the World Health Organization and the Centers for Disease Control and Prevention. This social determinants of health approach incorporates health equity and resiliency as overarching and integrated practices, for a comprehensive health methodology was adopted by HIPMC as foundational to the CHIP Plan. Members of the committees utilized this framework by reviewing data and acknowledging community assets and deficits when framing the outcome goals and implementation plans.



Measurable Objectives

To jump-start progress towards the 5-year goals and identify meaningful milestones to mark progress, the HIPMC Steering Committee approved the use of a planning and implementation framework known as the *Health Equity Action Lab (HEAL)*. HEAL is grounded in *Human Centered Design* concepts. The framework is comprised of four main components below.



The initial Prep phase convenes a leadership team to review existing data and develop a topic to be addressed in the Action Lab. The Leadership team are people of influence in the community who have the ability to clear the path for those who will be implementing the work in the next phase. The second step is the Action Lab phase, convening implementing partners together and includes those most affected by the work. The workers set ambitious goals for the 100-day period (the Sprint!), articulate a theory of change, and design the actions, deadlines, and people responsible for achieving the plan. Immediately following the Action Lab, the Sprint phase begins. In the 100 days, the work team will test initial theories to realize the goal; checking in weekly to review progress, lessons learned, and decide how they should move forward. The Sustain phase is the final time period and begins with a Momentum Lab. In the Momentum Lab, the group celebrates their 100 days of learning and creates an action plan for sustainability and for extended scalability.



Figure 11 Action Lab Photos

Through the HEAL process, HIPMC members identified the following measurable objectives to document progress towards the initial 100-day aim.

Goal: By 2023, 15% of medical providers (50% of which are pediatricians) in lowest life expectancy zones will utilize a closed-loop referral system addressing all 12 Elements of a Healthy Community .		
Deadline:	Measurable Objective:	Responsible Orgs:
January 2019	Pilot a closed-loop referral system addressing some Elements of a Healthy Community with one target population.	Arizona Coalition for Military Families, Crisis Response Network, Carl T Hayden VA Medical Center, UMOM,
December 2019	An operational closed-loop referral system that demonstrates effectiveness meeting	Arizona Coalition for Military Families, Crisis Response

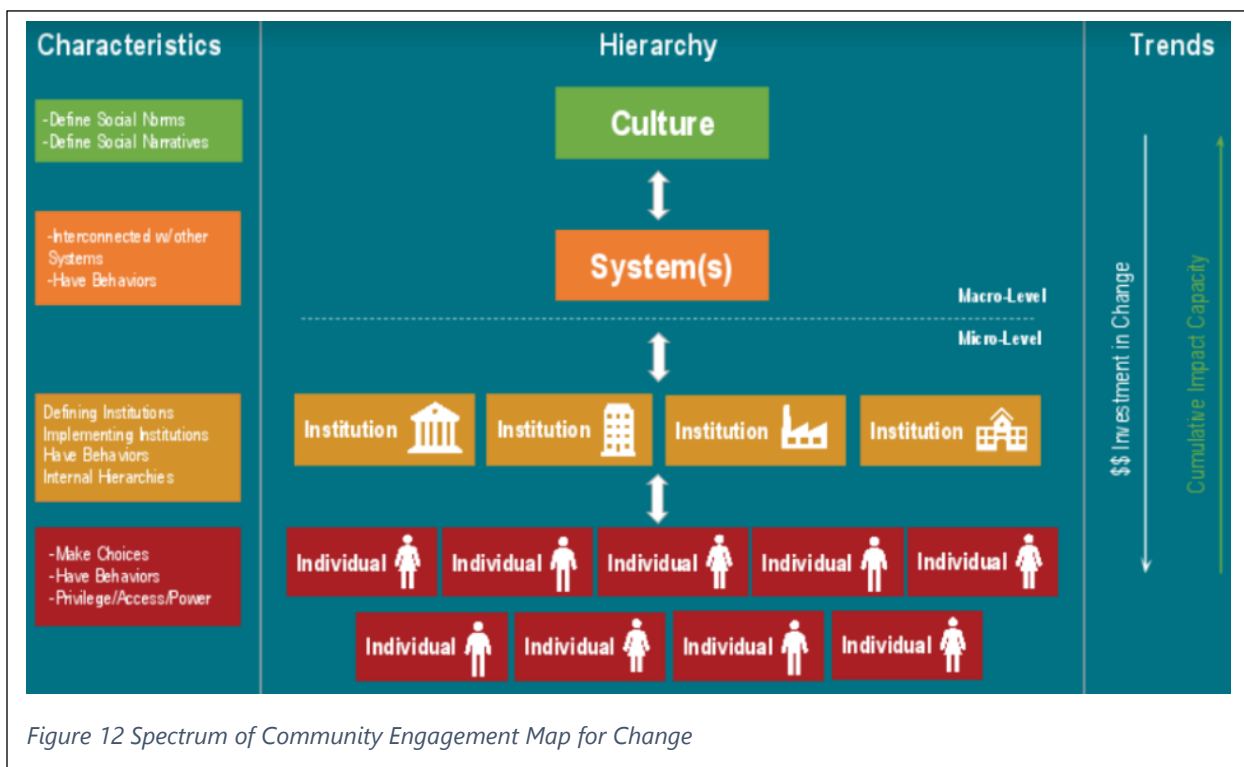
	Veteran's (and their families) social determinants of health needs is in place.	Network, Carl T Hayden VA Medical Center
December 2020	Suppliers representing services for at least 6 Elements of a Healthy Community will utilize a closed-loop referral system to improve individuals' well-being.	Arizona Coalition for Military Families, Crisis Response Network, Carl T Hayden VA Medical Center and others to be determined
December 2021	Suppliers representing services for all 12 Elements of a Healthy Community will utilize a closed-loop referral system to improve individuals' well-being.	Arizona Coalition for Military Families, Crisis Response Network, Carl T Hayden VA Medical Center and others to be determined
December 2022	8% of medical providers (50% pediatricians) in Lowest Life Expectancy zones are utilizing a closed-loop referral system addressing all 12 Elements of a Healthy Community .	Arizona Coalition for Military Families, Crisis Response Network, Carl T Hayden VA Medical Center and others to be determined

Goal: By the end of 2023, 100 food outlets in low access areas of Maricopa County will be distributing locally grown produce that weren't prior to 2018.		
Deadline:	Measurable Objective:	Responsible Orgs:
January 2019	By January 11th, 2019 the food access workgroup will work with farmers at Spaces of Opportunity to provide 50 total families experiencing immediate need for food across 5 Roosevelt School District schools with fresh produce.	Orchard Community Learning Center, MCDPH, Maricopa County Food Systems Coalition, City of Phoenix, Valley of the Sun United Way, Association of AZ Food Banks, American Heart Association, Roosevelt School District, Maricopa Integrated Health Services
December 2019	By December 31st, 2019 the Fresh Connections team will work with farmers at Spaces of Opportunity to provide families experiencing immediate need for food (from 14 Roosevelt School District Schools and 1 MIHS clinic) with fresh produce.	Orchard Community Learning Center, MCDPH, Maricopa County Food Systems Coalition, City of Phoenix, Valley of the Sun United Way, Association of AZ Food Banks, American Heart Association, Roosevelt School District, Maricopa Integrated Health Services
December 2020	By December 31st, 2020 the Fresh Connections team will work with farmers at Spaces of Opportunity to provide families experiencing immediate need for food (from all 19 Roosevelt School District Schools, 1	Orchard Community Learning Center, MCDPH, Maricopa County Food Systems Coalition, City of Phoenix, Valley of the Sun

	MIHS clinic, 3 Osborn/Isaac District Schools, 6 additional clinics, 4 retail stores, 2 subsidized housing units, and 2 farmers markets/pop up stands) with fresh produce.	United Way, Association of AZ Food Banks, American Heart Association, Roosevelt School District, Maricopa Integrated Health Services, Osborn/Isaac School District
December 2021	By December 31st, 2021 the Fresh Connections team will work with farmers at Spaces of Opportunity to provide families experiencing immediate need for food (from all 35 previous outlets plus 3 worksites, 10 more schools, 4 clinics/hospitals, and 8 religious/early care sites) with fresh produce.	Orchard Community Learning Center, MCDPH, Maricopa County Food Systems Coalition, City of Phoenix, Valley of the Sun United Way, Association of AZ Food Banks, American Heart Association, Roosevelt School District, Maricopa Integrated Health Services, Osborn/Isaac School District and others to be determined
December 2022	By December 31st, 2022 the Fresh Connections team will work with farmers at Spaces of Opportunity to provide families experiencing immediate need for food (from all 60 previous outlets plus 2 additional retail stores, 5 subsidized housing units, 10 additional schools, 1 additional farmers market, 5 worksites, and 2 clinics/hospitals/WIC sites) with fresh produce.	Orchard Community Learning Center, MCDPH, Maricopa County Food Systems Coalition, City of Phoenix, Valley of the Sun United Way, Association of AZ Food Banks, American Heart Association, Roosevelt School District, Maricopa Integrated Health Services, Osborn/Isaac School District and others to be determined
December 2023	By December 31st, 2023 the Fresh Connections team will work with farmers at Spaces of Opportunity to provide families experiencing immediate need for food (from all 85 previous outlets plus an additional 15 chosen based on the previous work) with fresh produce.	Orchard Community Learning Center, MCDPH, Maricopa County Food Systems Coalition, City of Phoenix, Valley of the Sun United Way, Association of AZ Food Banks, American Heart Association, Roosevelt School District, Maricopa Integrated Health Services, Osborn/Isaac School District and others to be determined

Policy and System Changes Needed

CHIP action planning with MCDPH is focused on policy and systems change approaches. Beginning with the initial planning workgroups, members reviewed the *Spectrum of Community Engagement for Change* framework (below) from Vitalyst Health Foundation, a HIPMC Champion Partner. This framework explains and demonstrates the priority of macro-level strategy for larger community impact and set the stage for systems-level work.



The goals and objectives developed during the HEAL focused on systems-level strategy to reach the five-year goals. Following the initial 100-day Sprint, the workgroup members participated in a second retreat-style planning day; Momentum Labs, taking place in January 2019. During the Momentum Lab, the two workgroup teams celebrated progress, reviewed their learnings, and continued the action planning process to build out the necessary components to achieve the five-year goals. Throughout the CHIP cycle, Momentum labs are planned annually to provide the space to review, update, and track progress on these strategy components.

Goal: By 2023, 15% of medical providers (50% of which are pediatricians) in lowest life expectancy zones will utilize a closed-loop referral system addressing all 12 Elements of a Healthy Community .		
System Changes Needed:	Policy Changes Needed:	Responsible Orgs:
Staff at the referral system hub organization(s) improve processes. Referral mechanisms identified and refined. Align key systems for participation – internal and external. CRN connected HIE potential AHCCCS pilot.	Organizational policies and procedures updated. Support Bill for 211 funding. New statewide crisis system.	Arizona Coalition for Military Families, Crisis Response Network, Carl T Hayden VA Medical Center, UMOM

Goal: By 2023, 100 food outlets in low access areas of Maricopa County will be distributing locally grown produce that weren't prior to 2018.		
System Changes Needed:	Policy Changes Needed:	Responsible Orgs:
-UA SNAP-Ed supports Roosevelt School District in implementing/revising Local Wellness Policies and support school gardens -CHP/GAP certification of Spaces of Opportunity farmers	Rx referrals for fresh fruits/vegetables at MIHS pediatric clinic based on food insecurity screenings and BMI/health indicators redeemed through vouchers at SOO.	Orchard Community Learning Center, MCDPH, Maricopa County Food Systems Coalition, City of Phoenix, Valley of the Sun United Way, Association of AZ Food Banks, American Heart Association, Roosevelt School District, Maricopa Integrated Health Services

Improvement Strategies

The HEAL model is grounded in improvement science principles that value learning through implementation and small-scale testing. Thus, the improvement strategies outlined during the first three phases of the HEAL model rely heavily on rapid cycle testing and focused learning through check-in calls. During the second phase of the model, known as the Action Lab, teams identified change theories after setting 100-day goals. In the third phase, the Sprint, they then tested individual components of those theories using the Plan, Do, Study, Act (PDSA) framework. These activities were discussed during weekly check-in calls and documented using an online spreadsheet. During the Momentum Lab which kicked off the 4th phase of the HEAL model, teams identified subsequent improvement strategies to align with their measurable objectives or annual milestones. These preliminary strategies are detailed below.

Goal: By 2023, 15% of medical providers (50% of which are pediatricians) in lowest life expectancy zones will utilize a closed-loop referral system addressing all 12 Elements of a Healthy Community .		
Measurable Objective:	Improvement Strategies:	Responsible Org:
By January 11, 2019, pilot a closed-loop referral system addressing some Elements of a Healthy Community with one target population.	Utilize Crisis Response Network's Be Connected Line to explore how to best connect housing insecure veterans with needed resources to learn what centralized referral system should include.	Arizona Coalition for Military Families, Crisis Response Network, Carl T Hayden VA Medical Center, UMOM
By December 2019, an operational closed-loop referral system that demonstrates effectiveness meeting Veteran's (and their families) social determinant of health needs is in place.	Build Infrastructure (resources/\$ for staffing, etc.) Map and track capacity of partners/suppliers Develop standardized SDOH screening protocol for veterans and families Build out and further pilot system for addressing veterans' "multiple SDOH" (not just housing) needs by connecting to existing resources and closing the loop on these referrals.	Arizona Coalition for Military Families, Crisis Response Network, Carl T Hayden VA Medical Center, UMOM
By December 2020, suppliers representing services for at least 6 Elements of a Healthy Community will utilize a closed-loop referral system to improve individuals' well-being.	Determine 6 elements to focus on first Engage key partners by focus on the gaps in available services/elements or eligibility criteria. Adapt screening protocol for general population Expand closed-loop system to other target audiences Training, promoting, incentivizing participation by organizations	Arizona Coalition for Military Families, Crisis Response Network Others, to be determined based on early adopters
By December 2021, suppliers representing services for all 12 Elements of a Healthy Community will utilize a closed-loop referral system to improve individuals' well-being.	Continue 2020 strategies focusing on expansion of breadth and depth. Use behavior design to test out best way to recruit and engage medical providers – motivation, incentives, etc.	Arizona Coalition for Military Families, Crisis Response Network Others, to be determined based on early adopters
By December 2022, 8% of medical providers (50% pediatricians) in Lowest Life Expectancy zones are utilizing a closed-loop referral system	Continue to implement and adapt best strategies from previous years to secure needed infrastructure.	Arizona Coalition for Military Families, Crisis Response Network Others, to be

addressing all 12 Elements of a Healthy Community .	Fine-tune recruitment methods for medical providers Specifically target pediatricians	determined based on early adopters
By December 2023, 15% of medical providers (50% pediatricians) in Lowest Life Expectancy zones, are utilizing a closed-loop referral system addressing all 12 Elements of a Healthy Community.	Continue to implement and adapt best strategies from previous years. Fine-tune recruitment methods for medical providers/Pediatricians	Arizona Coalition for Military Families, Crisis Response Network Others, to be determined based on early adopters

Goal: By 2023, 100 food outlets in low access areas of Maricopa County will be distributing locally grown produce that weren't prior to 2018.		
Measurable Objective:	Improvement Strategies:	Responsible Orgs:
By January 11th, 2019 the food access workgroup will work with farmers at Spaces of Opportunity to provide 50 total families experiencing immediate need for food across 5 Roosevelt School District schools with fresh produce	<ul style="list-style-type: none"> -Test a voucher redemption process -Connect families who are identified by school staff with food grown at OCLC 	Orchard Community Learning Center, MCDPH, Maricopa County Food Systems Coalition, City of Phoenix, Valley of the Sun United Way, Association of AZ Food Banks, American Heart Association, Roosevelt School District, Maricopa Integrated Health Services
By December 31st, 2019 the Fresh Connections team will work with farmers at Spaces of Opportunity to provide families experiencing immediate need for food (from 14 Roosevelt School District Schools and 1 MIHS clinic) with fresh produce	<ul style="list-style-type: none"> -Refine voucher redemption process - Train one staff member at each outlet to coordinate redemption program - Spread voucher program to 9 more schools - Test voucher redemption process in 1 MIHS clinic - Establish funding mechanisms - Test fundraising strategies 	Orchard Community Learning Center, MCDPH, Maricopa County Food Systems Coalition, City of Phoenix, Valley of the Sun United Way, Association of AZ Food Banks, American Heart Association, Roosevelt School District, Maricopa Integrated Health Services
By December 31st, 2020 the Fresh Connections team will work with farmers at Spaces of Opportunity to provide families experiencing immediate need for food (from all 19 Roosevelt School	<ul style="list-style-type: none"> -Spread voucher program to 3 more schools in a least 1 other district - Spread voucher redemption process to 6 additional MIHS clinic 	Orchard Community Learning Center, MCDPH, Maricopa County Food Systems Coalition, City of Phoenix, Valley of the Sun United Way,

District Schools, 1 MIHS clinic, 3 Osborn/Isaac District Schools, 6 additional clinics, 4 retail stores, 2 subsidized housing units, and 2 farmers markets/pop up stands) with fresh produce.	<ul style="list-style-type: none"> - Test process for 4 retail stores to offer locally grown produce - Test process for 2 subsidized housing units to offer locally grown produce - Test process to create 2 farmers markets/pop-up stands to offer locally grown produce - Identify sustaining funding for diversified outlets 	Association of AZ Food Banks, American Heart Association, Roosevelt School District, Maricopa Integrated Health Services
By December 31st, 2021 the Fresh Connections team will work with farmers at Spaces of Opportunity to provide families experiencing immediate need for food (from all 35 previous outlets plus 3 worksites, 10 more schools, 4 clinics/hospitals, and 8 religious/early care sites) with fresh produce.	<ul style="list-style-type: none"> - Spread voucher program to 10 additional schools - Spread voucher program to 4 additional clinics/hospitals - Identify process for creating outlets other than voucher programming - Test process for 3 worksites to offer locally grown produce - Test process for 8 religious/early care sites to offer locally grown produce 	Orchard Community Learning Center, MCDPH, Maricopa County Food Systems Coalition, City of Phoenix, Valley of the Sun United Way, Association of AZ Food Banks, American Heart Association, Roosevelt School District, Maricopa Integrated Health Services
By December 31st, 2022 the Fresh Connections team will work with farmers at Spaces of Opportunity to provide families experiencing immediate need for food (from all 60 previous outlets plus 2 additional retail stores, 5 subsidized housing units, 10 additional schools, 1 additional farmers market, 5 worksites, and 2 clinics/hospitals/WIC sites) with fresh produce.	<ul style="list-style-type: none"> - Spread voucher program to: <ul style="list-style-type: none"> 10 additional schools 2 additional clinics/hospitals/WIC sites - Spread other outlet methods to: <ul style="list-style-type: none"> 5 additional housing units 5 additional worksites 2 additional retail locations 1 additional farmers market 	Orchard Community Learning Center, MCDPH, Maricopa County Food Systems Coalition, City of Phoenix, Valley of the Sun United Way, Association of AZ Food Banks, American Heart Association, Roosevelt School District, Maricopa Integrated Health Services

Additional structural elements to support successful implementation of these strategies over time were also discussed during the January 2019 Momentum Lab. These included:

- Leadership
- Recruitment
- Communication
- Engagement
- Operational Logistics
- Evaluation
- Data Sharing
- Finance/Budget

A matrix showing how these elements were scoped for each group called *Scale-Up Grid* will be updated annually in accordance with the annual Momentum Lab review process.

	Year 1	Year 2	Year 3	Year 4	Year 5
Goal/Milestone					
Strategies					
System Changes Needed					
Policy Changes Needed					
Leadership					
Recruitment					
Communication					
Engagement					
Operational Logistics					
Process Evaluation					
Outcome Evaluation					
Operational Evaluation					
Data Sharing					
Finance/Budget					

Figure 13 Scale-Up Grid

Workgroup Structure and Action Plan Implementation

The milestones, strategies and structural elements identified in the Scale-Up Grids form a scaffolding for CHIP action plan implementation. This includes the ongoing function of collaborative workgroups. Workgroups for each major action area are supported by the MCDPH CHIP Project Team. Each workgroup establishes a regular meeting schedule and develops a concrete action plan that will support the implementation of the current year's improvement strategies. Implementation of Plan, Do, Study, Act (PDSA) cycles is encouraged during the implementation of these plans to regularly assess progress and adjust future tasks based off real-world learning. For this reason, action plans are not developed for more than 12 months at a time and are continually reviewed and revised during regular workgroup meetings and the annual Momentum Lab.

Process for Ongoing Review and Revision

The success of the HEAL model began by establishing initial objectives and strategies toward 5-year CHIP goals. Following the 100-day Sprint, the Momentum Lab set the action plan for the following year. As mentioned previously, the annual Momentum Labs revisit annual progress via components on the Scale-up Grids and adjust the action plans for the following year. Between the annual reviews, workgroup check-ins occur as needed to maintain progress and the cooperative relationships with the implementing organizations.

Process for Ongoing Evaluation

The following table presents the framework for the CHIP evaluation. The first two rows describe “how we work” and is designed around continuous learning to improve the HIPMC collaborative and the CHIP process overall. The bottom section focuses on “what we accomplish;” the outcomes realized because of the CHIP. A detailed narrative of these evaluative components follows.

	WHAT	HOW	WHEN	WHO
HOW WE WORK	NETWORK EVALUATION Measuring the strength and progress of HIPMC	<ul style="list-style-type: none"> Community of Solutions-Readiness Diagnostic Tool Wilder Collaboration Factors Inventory 	Annually	MCDPH Evaluation Team
	DEVELOPMENTAL EVALUATION Assessing the CHIP process	<ul style="list-style-type: none"> Meeting Evaluations Process Observations 	Ongoing	MCDPH Evaluation Team
WHAT WE ACCOMPLISH	CHIP OUTCOMES Progress towards improving health outcomes related to the CHIP priority areas	<ul style="list-style-type: none"> CHIP Dashboard via MySidewalk Secondary Data Review 	Ongoing	MCDPH Epidemiologists
	COLLECTIVE CHIP WORK Tracking workgroup progress towards reaching aims	<ul style="list-style-type: none"> Scale-Up Grid Actions Focus Population Surveys 	Momentum Lab and Ongoing Check-Ins	MCDPH Evaluation Team & Priority Area Workgroups
	PARTNERS' CHIP WORK Capturing successful initiatives that contribute to better CHIP outcomes	<ul style="list-style-type: none"> Success Stories via MySidewalk 	Quarterly	HIPMC Steering Committee

Figure 14 CHIP Evaluation Framework

Network Evaluation. This survey includes components from the *SCALE Community of Solutions-Readiness Diagnostic Tool* and the *Wilder Collaboration Factors Inventory*. Both tools have been validated to assess coalition functioning. This is an annual survey with a longitudinal look at HIPMC functioning. Results are presented to the HIPMC for interpretation and to identify opportunities and strategies for improvement.

Developmental Evaluation. Members of the MCDPH CHIP Project Team and Evaluation Team serve as observers to the CHIP planning and implementation processes, documenting decision making and continuous learning. Observations are shared with the appropriate groups in order for continuous improvement.

CHIP Outcomes. A number of population surveillance measures have been identified for each of the three priority areas for annual tracking. These data are reported on the public-facing platform MySidewalk.com. These measures include both county-wide outcomes and more specific data representations of measures delineating disparities. Since most of the data comes from secondary sources, HIPMC members can provide primary data to include on this Dashboard. (See [Maricopa County CHIP Dashboard](#).)

Collective CHIP Work. The collective CHIP work is the output of the HEAL Action Lab and Momentum Labs. Reporting for this work began with the culmination of the first 100-day Sprint. Ongoing monitoring and reporting occur at the workgroup check-ins and annually at the Momentum Labs.

Partners' CHIP Work. The HIPMC partners are committed to improving public health outcomes for the three designated priority areas. The partners regularly provide services in at least one of the priority areas. This work is in addition to the collective workgroup strategies described above and is important to building and sustaining healthy communities. Success stories of the work being conducted by HIPMC partners will be collected by the HIPMC Steering Committee and posted on the CHIP Dashboard.

To learn more about the health assessment and community health improvement planning process for Maricopa County, visit [Maricopa County CHIP Dashboard](#).



CHIP Workgroup Facilitation Community of Solutions Information

The Community Health Improvement Plan (CHIP) is designed to guide community wide collaborative efforts to improve health and well-being in specific areas related to the priority issue areas identified through the 2017 Community Health Assessment. In addition to looking at best practices and ensuring efforts align with [Public Health Accreditation](#) guidelines, The Health Improvement Partnership of Maricopa County (HIPMC) is participating in an international campaign called [100 Million Healthier Lives](#). Specifically, HIPMC is a [SCALE 1.0 community](#) that has received specific training and support over the past two years and will be continuing to implement the [SCALE Community of Solutions Model](#) in their work as well as becoming a catalyst for spreading these concepts and tools to nearby communities and other coalitions within Maricopa County.

The [Core Concepts and Principles of the Community of Solutions](#) model are summarized on page 2, and the following tools and related concepts are especially relevant to the CHIP Workgroup process. Each will be discussed in more detail at the scheduled facilitator training:

- SWITCH Framework provides a common language and philosophy for managing change
- Meaningful engagement of community members with lived experience
- Intentionally, deliberately and transparently addressing equity in all we do
- Data driven decision-making rooted in a solid theory of change
- Use of aspirational aims to inspire and quantify outcome goals
- Use of improvement science (QI) tools including the Model for Improvement

The CHIP workgroup process has been planned to incorporate these components and produce results which align with these concepts, priorities of HIPMC Steering Committee, and SCALE grant deliverables. We will ensure the following are completed:

1. **Who's Not Thriving?**
Select a specific population focus that addresses who's not thriving
2. **What is Currently Happening?**
Develop a picture of the organizations, people, relationships, and resources which exist in the focus area
3. **What Do We Want to See Improve in the Next 3 Years?**
Define a measurable, time-bound 3-year aim
4. **What Primary Drivers Need to Move in Order to Reach Our Goal?**
Visualize a theory of change on a driver diagram
5. **What is the Action Plan for 2018?**
Create an action plan and measurement system that allows for continual improvement and real-time results-based decision making.

MCDPH staff, who are well-versed in the Community of solution model, along with workgroup facilitators, will co-design workgroup activities that meet these needs while being responsive to and flexible, to accommodate the needs and desires of workgroup participants.

Core Concepts and Principles of a Community of Solutions

<p>How people relate to themselves, each other, and those most affected by inequity:</p> <ol style="list-style-type: none"> 1. The community is seen as an interconnected network; the improvement work reflects this perception and leadership is distributed within the network. 2. People with lived experience of inequity work together with community connectors and resource stewards to co-design and drive change. 3. A critical mass of people see themselves as stewards of the community's well-being, with the agency and capacity to create change. 4. Leaders across the community work together strategically to create the improvements, systems, and policies needed to sustain long-term change. 5. Community leaders prioritize equity and create a change process that offers greater ownership to those with lived experience of inequity. 6. People reflect, ask open and honest questions, address and resolve conflicts, and embrace differences in a constructive way. 	<p>How the community creates abundance:</p> <ol style="list-style-type: none"> 7. Stewards across sectors coordinate and leverage their assets in usual and unusual ways to address the priority needs of the community. 8. Leaders at all levels have the trust and governance processes in place to share resources and accountability. 9. Leaders prioritize the unlocking of untapped potential in people and organizations as a pathway to abundance. 10. Leaders support the development of other leaders who contribute to solutions at every level of the community. 11. Leaders invest in a change process that is dynamic and enhances engagement, relationship, capacity, and the will for change. 12. Leaders invest in the development of social change in a way that gives a wide range of people increasing agency in the change process for themselves and for their communities.
<p>How the community approaches the change process:</p> <ol style="list-style-type: none"> 13. Believe change is possible and define a tangible, motivating vision with concrete aims. 14. Co-design change with the person, place or population. 15. Recognize that solutions can come from anywhere — and create the space and process for their emergence, through the application of effective facilitation and design methods. 16. Focus on getting to meaningful outcomes, with a clear theory of change and measurement aligned with the theory. 17. Approach change in a dynamic way — community members learn, adapt, and “fail forward” as a normal part of creating change in small and big ways. 18. Use data and stories to drive improvement and monitor impact. 19. Adapt aims and measures as the community learns. 20. Embrace the opportunity to learn from others. 21. Display humility and a willingness to adopt solutions generated by others. 22. Focus on community strengths and bright spots, approaching challenges as opportunities. 23. Understand and prioritize the growth of trust, joy, meaning, motivation, and relationship in the change process. 24. Understand the system of the community from multiple perspectives. 25. Prioritize people and places that aren't thriving. 26. Address equity in a way that builds trust, resilience, and unity. 27. Unapologetically and pragmatically address structural racism and inequity in processes and systems. 28. Plan for sustainability, spread, and scale from the beginning. 	